STATE BOARD OF CONTROL
VICTIMS OF CRIME PROGRAM
BC-VOC-0101 (REV. 5/00)

MENTAL HEALTH
BILLING/VERIFICATION (B/V) FORM

FOR BOARD USE ONLY

(1) VOC CLAIM NUMBER

THIS FORM MUST BE COMPLETED FULLY

SECTION 1: TO BE COMPLETED BY THE SERVICE PROVIDER AND INITIALED BY THE PATIENT

(2) NAME OF PROVIDER ORGANIZATION OR FACILITY (IF APPLICABLE)	☐ FOR PROFIT	☐ NONPROFIT

(3) NAME OF TREATING THERAPIST	(4) LICENSE./REGISTRATION NO.(include prefix)	EFFECTIVE/EXPIRATION DATE

TREATING THERAPIST'S LICENSE TYPE:	☐ MFT	☐ MFT INTERN	☐ LCSW	☐ ASSOCIATE MSW

☐ PSYCHIATRIST	☐ PSYCH. ASSISTANT	☐ LICENSED CLINICAL PSYCHOLOGIST	☐ OTHER (PLEASE SPECIFY) _____

(5) NAME AND TITLE OF SUPERVISING THERAPIST (FOR INTERNS)	(6) SUPERVISOR'S LICENSE NUMBER (include prefix)	EFFECTIVE/EXPIRATION DATE OF SUPERVISING THERAPIST'S LICENSE

(7) IF AUTHORIZED, PAYMENT SHOULD BE ISSUED TO: ☐ ORGANIZATION ☐ TREATING THERAPIST ☐ SUPERVISING THERAPIST

(8) PAYEE'S TAX IDENTIFICATION NO.: SSN [ ] _____ **OR** EIN [ ] _____

(9) MAILING ADDRESS OF PAYEE (Including city, state, and zip code)	IS THIS A NEW ADDRESS?	TELEPHONE (Include area code)
	☐ YES ☐ NO	

(10) DATES OF SERVICE	(11) DESCRIPTION OF SERVICE (INDIVIDUAL, GROUP, FAMILY, OTHER)				PROCEDURE CODE	SESSION LENGTH	BILLED AMOUNT	(12) PATIENT'S INITIALS
	☐ IND	☐ GRP	☐ FAM	☐ OTHER				
	☐ IND	☐ GRP	☐ FAM	☐ OTHER				
	☐ IND	☐ GRP	☐ FAM	☐ OTHER				
	☐ IND	☐ GRP	☐ FAM	☐ OTHER				
	☐ IND	☐ GRP	☐ FAM	☐ OTHER				

PART OF TREATMENT NECESSARY TO ADDRESS THE EFFECTS OF THE QUALIFYING CRIME: 50% OR LESS ☐ OVER 50% ☐ 100% ☐	TOTAL CHARGES FOR THIS BILL

AMT PAID BY PATIENT	DOES PT. HAVE INSURANCE? ☐ YES ☐ NO	AMOUNT BILLED TO & PAID BY INSURANCE	DO YOU ACCEPT MEDI-CAL? ☐ YES ☐ NO

AMOUNT WRITTEN OFF	AMOUNT PAID BY OTHER	IF PAID BY OTHER, WHOM WAS THE PAYMENT MADE TO?

Is the counselor funded partially or wholly by **Federal VOCA grants or matching funds**? ☐ YES ☐ NO
NOTE: IF THE ANSWER IS YES, THESE SERVICES ARE **NOT** ELIGIBLE FOR REIMBURSEMENT FROM THE VOC PROGRAM

PROVIDER DECLARATION: I declare under penalty of perjury under the laws of the State of California (Penal Code sections 72, 118, and 129) that: (1) I have read all of the questions contained on this form, and to the best of my information and belief, all my answers are true, correct, and complete, and; (2) all treatment noted on this form was necessary as a direct result of the crime described on the patient's original Crime Victim Compensation Application. I further understand that if I have provided any information that is false, intentionally incomplete, or misleading, I may be found liable under Government Code section 12650 for filing a false claim with the State of California and may also be guilty of a misdemeanor or felony, punishable by six months or more in the county jail, up to four years in state prison, and/or fines up to ten thousand dollars ($10,000).

_____ _____ _____ _____
THERAPIST'S SIGNATURE DATE SUPERVISING THERAPIST'S SIGNATURE DATE

(14) SECTION II: TO BE COMPLETED BY PATIENT

PATIENT NAME (First, middle initial, last)	SOCIAL SECURITY NO.	DATE OF BIRTH	PHONE NO. (Work/home)

MAILING ADDRESS (Including city, state, and zip code	IS THIS A NEW ADDRESS? YES [ ] NO [ ]

PATIENT DECLARATION: I declare under penalty of perjury that I received the services listed on he date(s) indicated, that all treatment sessions on this form are directly related to the crime described on my original Crime Victim Compensation Application and that I have signed/initialed this form only after the services were provided.

_____ _____
(15) PATIENT'S SIGNATURE (Parent or Guardian's Signature if Patient is under age 18) DATE